Today's Date: _____

Enhance Life CHIROPRACTIC

APPLICATION FOR CARE AT ENHANCE LIFE CHIROPRACTIC

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ___/___/___ Age: ____ ☐Male ☐Female

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Home Phone: _____ Cell Phone: _____

Martial Status: ☐Single ☐ Married Number of Children & Ages: _____

Employer: _____ Occupation: _____

Work Phone: _____ Social Security Number: _____

Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by *circling the number*:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐late PM

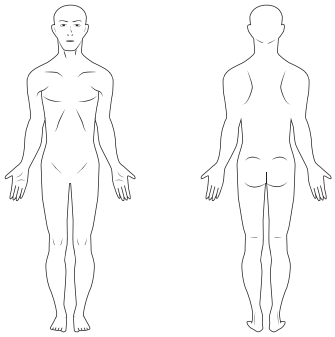
How long does it last? ☐It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the day

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of previous chiropractor: _____ ☐ N/A



***PLEASE MARK** the areas on the diagram with the following **letters** to describe your symptoms:
R = **R**adiating B = **B**urning D = **D**ull A = **A**ching N = **N**umbness S = **S**harp/Stabbing T = **T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL:**	**USUAL ACTIVITY LEVEL:**

Is your problem the result of ANY type of accident ☐Yes ☐No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

_____

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PAST HISTORY:

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes**, then how many times? _____
When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes**, then please state what type of treatment: _____
and who provided it: _____ **How long ago?** _____ What were the results: ☐ Favorable ☐ Unfavorable
Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for ***Never*** have had:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other Serious Conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASE			
ADULT DISEASE			

SOCIAL HISTORY:

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug Use: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies / Recreational Activities / Exercise Regime: How does your present problem affect activities of life?

_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
IF yes, whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ son ☐ daughter
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any hereditary conditions the doctor should be aware of? ☐ No ☐ Yes

_____

I hereby authorize payment to be made directly to Dr. Preston Benjamin, DC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that i will remain financially responsible to Enhance Life Chiropractic for any and all services I receive at this office.

_____ _____
Patient of Authorized Person's Signature Date Completed

_____ _____
Doctor's Signature Date Form Reviewed

Whom can we thank for referring you to our office? _____

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Activities of Daily Living/Symptoms/Medications

Patient Name: _____ **Date:** _____

Daily Activities: Effects of Current Conditions on Performance:

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

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Please mark with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for ***Never***:

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfunction
___ Jaw Pain (TMJ)	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation
___ Mid Back Pain	___ Pain w/ Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problems
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability
___ Numb/Tingling Arms, Hands, Fingers		___ ADD/ADHD	___ Eating Disorder
___ Numb/Tingling Legs, Feet, Toes		___ Allergies	___ Trouble Sleeping
___ Ulcers	___ Heartburn	___ Heart Problems	___ High Blood Pressure
___ Low Blood Pressure	___ Asthma	___ Difficulty Breathing	___ Lung Problems
___ Kidney Trouble	___ Gall Bladder Trouble	___ Liver Trouble	___ Hepatitis (A,B,C)

Would you like to receive our monthly newsletter? ☐ **Yes** ☐ **No**